

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on October 14, 2024. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 108	<p><b>27G .0202 (F-I) Personnel Requirements</b></p> <p><b>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</b></p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <ol style="list-style-type: none"> <li>(1) general organizational orientation;</li> <li>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</li> <li>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</li> <li>(4) training in infectious diseases and bloodborne pathogens.</li> </ol> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.</p>	V 108		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 1</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each staff had a valid First Aid and Cardiopulmonary Resuscitation (CPR) training certificate. The findings are:</p> <p>Reviews on 10/10/24 and 10/11/24 of each staff's personnel record revealed:</p> <ul style="list-style-type: none"> <li>-Staff #1 with a hire date of 7/31/23 as a Direct Care Technician (DCT) had a 7/31/23 American Red Cross (ARC) training certificate with former Staff #8's digital code on the certificate and completed training date of 9/3/20.</li> <li>-Staff #2 with hire date of 10/6/23 as a DCT had a 10/6/23 ARC training certificate with former Staff #8's digital code on the certificate and completed training date of 9/3/20.</li> <li>-Staff #4 with a hire date of 1/30/20 as a DCT had a 7/23/20 and 7/12/24 ARC training certificate with former Staff #8's digital code on the certificate and completed training date of 9/3/20.</li> <li>-Staff #5 with a hire date of 5/31/22 as a DCT had a 6/1/22 and 5/20/24 ARC training certificate with former Staff #8's digital code on the certificate and completed training date of 9/3/20.</li> <li>-Staff #6 with a rehire date in 3/2023 as a DCT had a 3/1/24 ARC training certificate with former Staff #8's digital code on the certificate and completed training date of 9/3/20.</li> </ul>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 2</p> <p>Review on 10/11/24 of the Former Director/Qualified Professional (QP)'s ARC certificate revealed: -5/30/24, he was certified as an ARC First Aid and CPR instructor.</p> <p>Review on 10/11/24 of the Director/QP's ARC certificate revealed: -9/20/24, she was certified as an ARC First Aid and CPR instructor.</p> <p>Interview on 10/7/24 with Staff #1 revealed: -He received his First Aid and CPR training from the Former Director/QP.</p> <p>Interview on 10/9/24 with Staff #2 revealed: -He received his First Aid and CPR training from the Former Director/QP.</p> <p>Interview on 10/11/24 with the Director/QP revealed: -Each training certificate through ARC cost money and this was the reason the Former Director/QP used former staff #8's ARC training certificate. -She was sure each of the current staff (#1- #6) was trained in First Aid and CPR by the Former Director/QP. -She would ensure the staff's ARC training certificates were corrected.</p>	V 108		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 3</p> <p>assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement a treatment plan for 1 of 3 clients (Client #2). The findings are:</p> <p>Review on 10/8/24 of Client #2's record revealed: -Admission date of 6/30/22. -Diagnoses of Autism, Epilepsy, Mood Disorder, Hypothyroidism, Hyperlipidemia -No current treatment plan.</p>	V 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	<p>Continued From page 4</p> <p>Interview on 10/7/24 with Client #2 revealed: - "I don't have any (goals) here (facility). I have goals at the day program I go to."</p> <p>Interview with the Director/Qualified Professional (QP) revealed: -She provided a treatment plan dated 6/30/22 for Client #2 which had: -the first goal was to maintain healthy hygiene habits such as teeth brushing, hand washing, and showering. -the second goal was to participate in community based or facility based social activities. -no staff strategies for how Client #2 would be helped by staff to achieve the stated goals. -no client, guardian or legally responsible person who signed the plan which indicated a review or consultation of the plan for a current treatment plan.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 112		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse,</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 5</p> <p>pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff who administered client medications were trained by a legally qualified and privileged person who could prepare and administer medications. The findings are:</p> <p>Reviews on 10/8/24 and 10/11/24 of each staff's personnel record revealed: -Staff #1 with a hire date of 7/31/23 as a Direct Care Technician (DCT) had 7/31/23 and 7/10/24 Medication Administration training certificates with a 1.0 training hour and training completed through an online program. -Staff #2 with a hire date of 10/6/23 as a DCT had a 10/6/23 and 10/1/24 Medication Administration</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/14/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>M &amp; S SUPERVISED LIVING, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 6</p> <p>training certificates with a 1.0 training hour and training completed through an online program.</p> <p>Interview on 10/7/24 with Staff #1 revealed: -He completed his Medication Administration training on computer.</p> <p>Interview on 10/9/24 with Staff #2 revealed: - He completed his Medication Administration training on computer and took a test on paper at the end of the training.</p> <p>Interviews on 10/8/24 and 10/10/24 with the Director/QP revealed: -Some staff had their initial training through a pharmacy service which was conducted in person. -She did not know how to get in contact with the registered nurse identified on the online Medication training certificates. -"Its just a program that's been downloaded on computer."</p>	V 118		